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DATE NOTICE SENT TO ALL PARTIES: Feb/06/2017

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: inject sacroiliac joint

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D. Board Certified Anesthesiology

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for inject sacroiliac joint is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a XX whose date of injury is XXXX. The patient was working as XX, and XX. She hit her head on the ceiling and then fell over a chair in an awkward position. The patient has a history of multiple surgeries including a fusion at L4-S1 in XXXX with revision secondary to broken pedicle screw in XXXX. She has been treated with sacroiliac joint injections. The patient underwent left sacroiliac joint injection on XXXX and XXX. The patient underwent bilateral sacroiliac joint injections on XXXX and left side sacroiliac joint injections on XXXX and XXXX. Office visit note dated XXXX indicates that the left sacroiliac joint injection on XXXX gave her greater than 60% relief for two months. She complains of left sided posterior hip and buttocks pain that radiates down the posterior leg to the knee. She is currently taking over the counter ibuprofen 600 mg three times a day with mild relief. On physical examination, lumbar range of motion is within normal limits. Strength is 5/5 in the lower extremities. Sensation is intact. Fortin Finger test, hip compression test and Gaenslen's test are positive on the left. Straight leg raise is negative bilaterally. FABER is positive on the left.

The initial request for left sacroiliac joint injection was non-certified on XXXX noting that the request has not been proven in large volume long term medical literature to be an effective treatment in this clinical setting. Fusion consideration is also not evident. Appeal letter dated XXXX indicates that the patient has a history of L4 to S1 fusion in XXXX with revision secondary to a broken pedicle screw. She complains of left sided posterior hip and buttocks pain that radiates down the posterior leg to the knee. She is currently taking over the counter ibuprofen 600 mg three times a day with mild relief. The patient is status post left sacroiliac joint injection on XXXX that gave her greater than 60% relief for two months. On physical examination, she has full lumbar range of motion. Strength is 5/5 in the lower extremities. Sensation is intact in the lower extremities. Deep tendon reflexes are symmetrical bilaterally. She has tenderness to palpation over the left sacroiliac joint area, positive hip compression test on the left side, positive Gaenslen's on the left, and positive Fortin finger test on the left side. A course of physical therapy was completed in XXXX with mild improvement. The denial was upheld on appeal dated XXXX noting that the documentation does not support the listed diagnosis of ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy. The

documentation does not substantiate the claimant has tried and failed conservative care prior to this. The claimant may have undergone some physical therapy, but documentation does not show they type or amount and what length of relief, if any, this provided.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted records indicate that the patient sustained XX. The patient was subsequently treated with lumbar fusion followed by subsequent revision. The patient has been treated with multiple sacroiliac joint injections and reported greater than 60% pain relief for XX months following the most recent sacroiliac joint injection on XXXX. However, there is no documentation of increased functional ability or decreased medication usage. There is also no documentation of any recent active treatment as the submitted records indicate that the patient last underwent a course of physical therapy in XXXX. As such, it is the opinion of the reviewer that the request for inject sacroiliac joint is not recommended as medically necessary, and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)